Government of the District of Columbia

# HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD

## STATUTORY AND REGULATORY AUTHORITY

***The Procurement Practices Human Care Agreement Amendment Act of 2000 (D.C. Law 13-155) authorizes the District of Columbia Chief Procurement Officer, or his or her designee, to award human care agreements for the procurement of social, health, human, and education services directly to individuals in the District. The Human Care Agreement Contractor Qualifications Record (CQR) is an application package that will facilitate the process of pre-qualifying potential contractors for a human care agreement with the District of Columbia in accordance with D.C. Law 13-155 and Chapter 19, Title 27 of the District of Columbia Municipal Regulations (DCMR).***

## GENERAL INSTRUCTIONS

1. *Please read and complete each section of the Human Care Agreement Contractor Qualifications Record form. All information must be completed in the spaces provided, or marked "N/A."*

2. *An original signature must be provided in those sections where a signature is required. Copies or a stamped signature **is not** acceptable.*

3. *Included in the package that will be provided to you will be a copy of the "Standard Contract Provisions For Use With District of Columbia Government Supply and Services Contracts", dated October 1, 1999. Please read this document carefully before you complete the Contractor's Qualifications Record. The "Standard Contract Provisions For Use With District of Columbia Government Supply and Services Contracts," dated October 1, 1999, will be incorporated by reference into each Human Care Agreement that is entered into between a contractor that will provide human care services and the District of Columbia.*

4. *Also included in the package that will be provided to you will be the forms listed below that will be a part of the Human Care Agreement Qualifications Record. Each applicant must complete these forms and return them along with the completed Human Care Agreement Contractor Qualifications Record in order to be considered as a potential human care contractor. If you have not been provided with a copy of these forms, please request them. The additional forms include:*

    a. *The certification package requirements for equal employment opportunity compliance in accordance with section 5 of Mayor's Order 85-85, "Equal Opportunity Obligations in Contracts;"*
    b. *The tax certification affidavit contained in section XI of this Human Care Agreement Contractor Qualifications Record; and*
    c. *The Drug-Free Workplace certification.*

5. *You may use Section VIII, the "Remarks Section", on page 7 of this form, to provide additional information or to expand on any information that is provided in response to a request for information in this form.*

6. *If you would like to be certified as a local, small, or disadvantaged business enterprise, you must complete the self-certification package required for compliance with Equal Opportunity for Local, Small and Disadvantaged Business Enterprises Amendment Act of 1998, as amended (D.C. Laws 12-268 and 13-169). Upon completion, the package must be submitted to the D.C. Office of Local Business Development.*

7. *Please make sure that you include and attach all information, documentation, and data as instructed and required.*

8. *In those instances where check boxes are provided, please check only the box or boxes that apply.*

## *SELECTION OF HUMAN CARE AGREEMENT CONTRACTORS*

1. The selection process for selecting contractors to provide human care services is set forth in Chapter 19 of Title 27 of the District of Columbia Municipal Regulations (DCMR).

2. In accordance with 27 DCMR § 1905.6, during the process of considering prospective contractors to provide human care services, a Contracting Officer shall certify the financial and professional responsibility of each prospective contractor based on the following criteria:
   - (a) The type of business or organization and its history;
   - (b) The resumes and professional qualifications of the business or organization's staff, including relevant professional and/or business licenses, affiliations, and specialties;
   - (c) Information attesting to financial capability, including financial statements;
   - (d) Specialized experience and technical competence in the type of work required;
   - (e) Capability to accomplish the work in the required time;
   - (f) A summary of similar contracts awarded to the service provider, and the service provider's performance of those contracts;
   - (g) A certification of compliance with all applicable tax and filing requirements;
   - (h) A statement attesting to compliance with wage, hour, workplace safety and other standards of labor law;
   - (i) A statement attesting to compliance with federal and District equal employment opportunity law;
   - (j) Information about pending lawsuits or investigations, and judgments, indictments, or convictions against the service provider or its proprietors, partners, directors, officers, or managers; and
   - (k) Acceptability to connect with other resources.
   - (l) Certification of **Liability Insurance** or ability to obtain the required insurance prior to award of a contract

## *CHECKLIST*

| | | | |
|---|---|---|---|
| ☐ | Did you include your Taxpayer Identification Number? | ☐ | Did you attach a copy of your most recent Financial Statement? |
| ☐ | Did you attach the information required In Section III, Disclosure Information? | ☐ | Did you attach a copy of all licenses and certifications, including any specialty certifications? |
| ☐ | Did you list all personnel critical to the performance of your Organization in Section VI | ☐ | Are you providing a facility? Then, did you attach a copy of the Certificate of Occupancy for each facility? |
| ☐ | Did you attach a Certificate of Incorporation, if applicable? | ☐ | Did you attach a Certificate of Good Standing, if applicable? |
| ☐ | Did you attach a copy of your LSDBE certification, if applicable? | ☐ | Did you attach or include your salary history, if an individual applicant? |
| ☐ | Did you attach a copy of your LSDBE certification, if applicable? | ☐ | Did you attach or include your Medicaid Provider Number, if applicable? |
| ☐ | Did you attach a copy of your Drug-Free Workplace certification statement? | ☐ | Did you complete and sign the Tax Certification contained in Section XI? |

## *FREQUENTLY ASKED QUESTIONS*

| | | | |
|---|---|---|---|
| **Q** | Can I fax my application for processing? | **A** | No. Contractor Qualifications Records must contain original, not copied signatures. |
| **Q** | Is this form available electronically? | **A** | Yes, the Contractor Qualifications Record (CQR) is available on the Office of Contracting and Procurement web site at **ocp@dcgov.org**. |
| **Q** | Who or what is an Individual? | **A** | The term "individual" means a human person who may be licensed, certified, or otherwise authorized or qualified to perform or provide specific human care services. The individual may be solo practitioner or a part of a group. |
| **Q** | Who or what is an Organization? | **A** | The term "organization" means an entity, other than an individual, that is licensed, certified, or otherwise authorized, or qualified, to provide or perform human care services in the normal course of business. The license, certification, or other recognition is granted to the organization entity. Individual owners, managers, or employees of the organization may also be certified, licensed, or otherwise recognized as individual providers in their own right. Examples may include a corporation, joint venture, clinic, hospital, or partnership. |
| **Q** | Who or what is an LSDBE? | **A** | The term "LSDBE" means "Local, Small, and Disadvantaged Business Enterprises. The term means the standards for local business enterprise contractors, small business enterprise contractors, and disadvantaged business enterprises, including those business enterprises located in enterprise zones located in the District of Columbia. In order to qualify for LSDBE status, a business enterprise must be certified by the D.C. Office of Local Business Development. |

Government of the District of Columbia

# HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD

| 1. DATE OF FILING | 2. FILING TYPE: ☐ NEW ☐ UPDATE ☐ CORRECTION ☐ REMOVAL | FOR OCP USE ONLY: *DATE RECEIVED BY OCP:* |
|---|---|---|

## SECTION I – GENERAL INFORMATION

1. NAME OF INDIVIDUAL/ ORGANIZATION

a. Name:

b. Title:

c. Physical Street Address:

d. City, State & Zip Code:

e. Office Phone: f. Office Facsimile No:

g. E-Mail:

5. SOCIAL SEC. / TAXPAYER ID NO:

6. DUNN & Bradstreet No:

2. TYPE OF ORGANIZATION *(Please check the appropriate box.)*

☐ INDIVIDUAL ☐ JOINT VENTURE

☐ CORPORATION ☐ GENERAL PARTNERSHIP

☐ SOLE PROPRIETORSHIP ☐ LIMITED PARTNERSHIP

3. STATE OF INCORPORATION *(Please check the appropriate box.)*

☐ DISTRICT OF COLUMBIA ☐ COMMONWEALTH OF VIRGINIA

☐ STATE OF MARYLAND ☐ STATE OF DELAWARE

☐ OTHER: _____

*Date Of:* _____

3. IS ORGANIZATION?

☐ FOR PROFIT ☐ NON-PROFIT

7. ARE YOU OR THE ORGANIZATION CERTIFIED IN D.C. AS?

☐ Local ☐ Small Disadvantaged ☐ Enterprise Zone

## SECTION II – FINANCIAL RESPONSIBILITY INFORMATION

**(Please Provide and Attach a Copy of Your Most Recent Financial Statement.)**

| 1. **Name and Address of Accountant:** | 2. Name and Address of Financial Institution: |
|---|---|
| **3. Name and Title of Contact Person:** | **4. Name and Title of Contact Person:** |
| **5. Telephone No.:** / **6. Fax No.:** | **7. Telephone No.:** / 8. Fax No.: |
| **9. Date Of Attached Financial Statement (Must be Within Last 12 Months):** | *10. Do You/Organization Owe Any Outstanding District /Federal Taxes:* District Taxes: ☐ NO ☐ YES - Federal Taxes: ☐ NO ☐ YES |

**11. MEDICAID – MEDICARE INFORMATION:**

a. Are You / Organization a Certified Medicaid Provider? ☐ YES ☐ NO Medicaid Number: _____ Date: _____

b. Are You / Organization a Certified Medicare Provider? ☐ YES ☐ NO Medicare Number: _____ Date: _____

## SECTION III – DISCLOSURE INFORMATION

(If yes to any questions below, please explain fully in REMARKS SECTION, or attach a separate statement. )

1. Have you or the Organization ever been debarred, suspended or sanctioned from any state or federal program?
☐ YES ☐ NO

2. Is your license, or any in the organization currently suspended or restricted in any way?
☐ YES ☐ NO

3. Have you or the principals of the Organization ever been, indicted, convicted of or pled guilty to a crime (excluding minor traffic citation), or been imprisoned for a crime in the past 10 years.:
☐ YES ☐ NO

4. Are there any judgments, or pending civil lawsuits, or investigations against you or the Organization, or its principals?:
☐ YES ☐ NO

5. Have you or the Organization ever had any outstanding criminal fines, restitution orders, or overpayments identified in the District or any state?:
☐ YES ☐ NO

6. Are you, or is anyone in your organization, related by blood or marriage to any individual employed by the District government?:
☐ YES ☐ NO

## SECTION IV – ORGANIZATION HISTORY, BACKGROUND AND EXPERIENCE

**1. List All Contracts With the District Government Within the Past Five (5) Years:**

| | Agency | Description of Service | Amount | Dates | Contract Number |
|---|---|---|---|---|---|
| A | | | | | |
| B | | | | | |
| C | | | | | |
| D | | | | | |
| E | | | | | |

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**2. List All Contracts With Other Governments or Private Institutions Within the Past Five (5) Years:**

| | Agency | Description of Service | Amount | Dates | Contract Number |
|---|---|---|---|---|---|
| A | | | | to | |
| B | | | | to | |
| C | | | | to | |
| D | | | | to | |
| E | | | | to | |

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**3. If You Are Applying As An INDIVIDUAL, Please List Your Employment Or Work History for past five (5) years:**

| | Name of Employer | Address | Duties | Name of Supervisor | Dates of Employment | Telephone |
|---|---|---|---|---|---|---|
| A | | | | | to | |
| B | | | | | to | |
| C | | | | | to | |
| D | | | | | to | |
| E | | | | | to | |
| F | | | | | to | |

*(Please Use and Attach a Separate Sheet for Salary History and Additional Items.)*

**4. List At Least Five (5) References Familiar With Service Delivery:**

| | Name | Tittle/Position | Affiliation | Telephone | Fax | E-Mail |
|---|---|---|---|---|---|---|
| A | | | | | | |
| B | | | | | | |
| C | | | | | | |
| D | | | | | | |
| E | | | | | | |

*(Please Use and Attach a Separate Sheet for Additional Items.)*

| 4. ARE YOU A UNIITED STATES CITIZEN? | 5. ARE YOU A PERMANENT RESIDENT? *(Please Attach Documentation To Support))* | 6. IF YOU ARE NOT A CITIZEN, CAN YOU PROVIDE AND SUBMIT VERIFICATION OF YOUR LEGAL RIGHT TO WORK IN THE UNITED STATES? *(Please Attach Documentation To Support.)* |
|---|---|---|
| ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |

## SECTION V – EDUCATION, CREDENTIALS AND LICENSURE

**1. Please List All Colleges (Undergraduate and Graduate) and Professional Institutions Attended:**

| | Chief Study Subject Area | Name of College, University or Professional School | Address and Zip Code | Dates Attended | Date And Type Degree Awarded |
|---|---|---|---|---|---|
| A | | | | To | |
| B | | | | To | |
| C | | | | To | |
| D | | | | To | |
| E | | | | To | |

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**2. Please List All Professional Certifications and Licenses (Copies Must Be Attached):**

| | License/Certification | Agency/Entity | State | Number | Effective Dates | Date Issued |
|---|---|---|---|---|---|---|
| A | | | | | to | |
| B | | | | | to | |
| C | | | | | to | |
| D | | | | | to | |
| E | | | | | to | |

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**3. Please List All Specialty, Certifications and Licenses (Copies Must Be Attached):**

| | Specialty License/Certification | Agency /Entity | State | Number | Effective Dates | Date Issued |
|---|---|---|---|---|---|---|
| A | | | | | to | |
| B | | | | | to | |
| C | | | | | to | |
| D | | | | | to | |

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**4. HAVE YOU OR ANY MEMBER OF THE ORGANIZATION EVER HAD ANY LICENSE, CERTIFICATION OR CREDENTIAL REVOKED OR SUSPENDED?** ☐ YES ☐ NO

**(***If yes, please explain in REMARKS SECTION, or attach a detailed explanation, including dates, type of license, certification, credential and all circumstances surrounding the event(s).)*

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**5. Please list any hospital affiliations or privileges below:**

| | Name of Individuals(s) | Name of Hospital | Address | Type Privilege/Affiliation | Telephone | Fax No. |
|---|---|---|---|---|---|---|
| A | | | | | | |
| B | | | | | | |
| C | | | | | | |
| D | | | | | | |

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**6. HAVE YOU OR ANY MEMBER OF THE ORGANIZATION EVER HAD ANY HOSPITAL PRIVILEGES REVOKED, FOR ANY REASON?** ☐ YES ☐ NO

**(***If yes, please explain in REMARKS SECTION, or attach a detailed explanation, including dates, type of license, certification, credential and all circumstances surrounding the event(s).)*

## SECTION VI – SERVICE DATA AND INFORMATION

**1. GENERAL SERVICE CATEGORIES: Please Check Each Of The General Service Categories For Which You Or The Organization Are Applying.**

- ☐ Education (EDS)
- ☐ Special Education (SED)
- ☐ Health (HTH)
- ☐ Employment/Vocational (EMP)
- ☐ Mental Health (MEN)
- ☐ Social Services /Human Services (SOC)
- ☐ Child Welfare (CWS)
- ☐ Youth/Juvenile Justice (JUV)
- ☐ _____

**2. POPULATIONS: Pleas Check All That Apply For Populations.**

- ☐ Children & Youth (CYG)
- ☐ Children & Youth-Detained (CYD)
- ☐ Children & Youth-Committed (CYC)
- ☐ Children & Youth-Supervision (CYS)
- ☐ Special Education (SED)
- ☐ Adults (ADT)
- ☐ Adult Forensic-Psychiatric (AFP)
- ☐ Adult Forensic-Correctional (FC)
- ☐ Physically Disabled (DIS)
- ☐ Mentally Retarded (MRD)
- ☐ Developmentally Disabled (DVD)
- ☐ Geriatric (GER)
- ☐ Pregnant Women (PGW)
- ☐ Hearing Impaired (HIM)
- ☐ Blind/Visually Impaired (BLD)
- ☐ Homeless (HLS)
- ☐ Multicultural (MLT)
- ☐ HIV/AIDS (HIV)
- ☐ Dually Diagnosed (DUD)
- ☐ _____

**3. SETTING CODES: Please Check The Settings Where You Or The Organization Can Or Will Provide Service.**
***(If You Or The Organization Has A Facility, Then A Certificate of Occupancy Must Be Included and Attached.)***

- ☐ Addiction Treatment Facility (ADF)
- ☐ Ambulatory Care/Surg Center (AMB)
- ☐ Child Development Center (CDC)
- ☐ Comm Day Program (CDP)
- ☐ Comm Health Center (CHC)
- ☐ Comm Residential Facility (CRF)
- ☐ Crisis Center (CRC)
- ☐ Foster Care Home (FCH)
- ☐ Detention Facility–Youth (DFY)
- ☐ Detention Facility –Adult (DFA)
- ☐ Dialysis Center (DIA)
- ☐ Group Home –Youth (YGH)
- ☐ Group Home-MR (MGH)
- ☐ Homeless Shelter (HOS)
- ☐ In the Field (FLD)
- ☐ Inpatient-Psychiatric (INP)
- ☐ Inpatient-Medical (INM)
- ☐ Intermed Care Center-MR (IMR)
- ☐ Laboratory (LAB)
- ☐ Nursing Care Facility (NCF)
- ☐ Outpatient Clinic (OTC)
- ☐ Private Home (PRH)
- ☐ Provider's Office or Facility (POF)
- ☐ School (SCH)
- ☐ _____

**4. SPECIFIC SERVICE CATEGORIES: Please Check the Specific Service Categories That Apply To You or The Organization in which you are qualified, including licenses, or certified, to provide services:**

- ☐ Addiction Treatment Services (ADT)
- ☐ Allergy (ALG)
- ☐ Addiction Treatment Services (ADT)
- ☐ Assessment/Diagnosis (ASS)
- ☐ Audiology (AUD)
- ☐ Assessment Diagnosis (ASD)
- ☐ Birthing Services (BIR)
- ☐ Case Management-Family Services (CMF)
- ☐ Case Management-Medical (CMM)
- ☐ Case Management-Social (CMS)
- ☐ Child Care Services (DAY)
- ☐ Chore Services (CHR)
- ☐ Consulting (CON)
- ☐ Counseling Services (CSL)
- ☐ Crisis Intervention Services (CRI)
- ☐ Day Treatment Services (Habilitation) (DTR)
- ☐ Dental Services (DEN)
- ☐ Dialysis Services (DIA)
- ☐ Early Childhood Intervention (ECI)
- ☐ EPSDT Screening (EPS)
- ☐ Family Services (FAM)
- ☐ Homemaker Services (HOM)
- ☐ Dental Hygienist (DHY)
- ☐ Laboratory Screening Services (LAB)
- ☐ Mental Health (MEN)
- ☐ Midwifery (MID)
- ☐ Music Therapy (MTH)
- ☐ Neurology (NEU)
- ☐ Nutrition and Dietary (NUT)
- ☐ Occupational Therapy (OTH)
- ☐ Optometry (OPT)
- ☐ Pediatric (PED)
- ☐ Personal Care Services (PCS)
- ☐ Physical Therapy (PTH)
- ☐ Podiatry (POD)
- ☐ Pre-Natal Services (PNA)
- ☐ Psychological Services (PSC)
- ☐ Psychiatric (PSY)
- ☐ Recreation Therapy (RTH)
- ☐ Respiratory Care Services (RES)
- ☐ Respite Care (RSC)
- ☐ Supported Employment Services (SES)
- ☐ Social Worker Services (SWS)
- ☐ Speech Therapy (STH)
- ☐ Transportation Services (TRS)
- ☐ Visiting Nurse (home) (VIS)
- ☐ Vocational Rehabilitation (VOC)
- ☐ _____

**5. LICENSURE AND CERTIFICATION CATEGORIES: Please Check All of the Licensure and Certification categories that Apply to You or the Organization in which you are qualified, And Are Licensed Or Certified To Provide Services:**

- ☐ Acupuncture Therapist (ACC)
- ☐ Advanced Practice Registered Nurse (ARN)
- ☐ Architect (ARC)
- ☐ Audiologist (AUD)
- ☐ Certificate of Occupancy (COO)
- ☐ Child Development (CHD)
- ☐ Dental Hygienist (DHY)
- ☐ Dentist (DEN)
- ☐ Chiropractor (CHP)
- ☐ Foster Care Provider (FOS)
- ☐ Funeral Directors (FUN)
- ☐ Gynecology (GYN)
- ☐ Massage Therapy (MAS)
- ☐ Naturopathy (NAT)
- ☐ Nurse-Anesthetist (RNA)
- ☐ Nurse-Midwife (RNM)
- ☐ Nurse Practitioner (RNP)
- ☐ Nutritionist & Dietician (NUT)
- ☐ Obstetrician (OBS)
- ☐ Occupational Therapist (OTH)
- ☐ Optometrist (OPT)
- ☐ Ophthalmology (OPG)
- ☐ Pharmacist (PHM)
- ☐ Physical Therapist (PTH)
- ☐ Physician (DOC)
- ☐ Physician Assistant (PAS)
- ☐ Podiatrist (POD)
- ☐ Practical Nursing (LPN)
- ☐ Professional Counseling (PRO)
- ☐ Psychologist (PSC)
- ☐ Psychiatrist (PSY)
- ☐ Registered Nurse (RNN)
- ☐ Respiratory Care (RES)
- ☐ Social Worker-Clinical (SWC)
- ☐ Social Worker (SWS)
- ☐ _____

**6. LANGUAGE SKILLS: Please Check All that Apply for Your Or The Organization's Language Skills:**

- ☐ English (ENG)
- ☐ Spanish (SPN)
- ☐ International/Universal Sign (SGN)
- ☐ Italian (ITL)
- ☐ French (FRN)
- ☐ Haitian Creole (CRE)
- ☐ Vietnamese (VTN)
- ☐ Korean (KOR)
- ☐ Chinese–Cantonese (CCA)
- ☐ Chinese-Mandarin (CMA)
- ☐ Ethiopian (Amharic) (AMH)
- ☐ _____

## SECTION VII – PERSONNEL CRITICAL TO ORGANIZATION PERFORMANCE

**1. Please list All of the Personnel In your Organization Who Are Critical To organization Performance. Please List Officers, Clinical Directors, Medical Directors, Service Supervisors, and Sub-Contractors Essential to the Performance of Services in this Qualifications Record and Attach Resumes Coded to this Section. Attach Any Copies of Licenses, Certifications, or Credentials Where Applicable.:**

| | *Name* | *Title/Position* | *Affiliation* | *Telephone* | *Fax* | *E-Mail* |
|---|---|---|---|---|---|---|
| A | | | | | | |
| B | | | | | | |
| C | | | | | | |
| D | | | | | | |

1. *Please use this section to respond to or to continue to response to any previous question, or request for information. In addition, please feel free to use this section to provide additional information vital to determining your or the organizations qualifications to enter into a Human Care Service Agreement with the District of Columbia.*

## *SECTION IX – CERTIFICATIONS AND INCORPORATIONS BY REFERENCE*

1. DRUG-FREE WORKPLACE CERTIFICATION: *Please provide Certification That You Or The Organization Does Or Will Operate In A Drug-Free Manner.*

I/We, _____ of _____

Hereby give, affirm and provide certification that I/We have received and have read the requirements on having and maintaining a Drug-Free Workplace in the District of Columbia, agree to be bound by those requirements and the remedies stated in the requirements, and further certify that I/We realize that making a false, fictitious, or fraudulent certification may render the maker subject to prosecution under Title 18, United States Code, Section 1001.

| *Name (Please Print)* | *Title* | *Signature* | *Date* |
|---|---|---|---|
| Peggy L. Harris | President | | |

*(May be signed on behalf of individual or organization.)*

2. **STANDARD CONTRACT PROVISIONS FOR USE WITH DISTRICT OF COLUMBIA SUPPLY AND SERVICES CONTRACTS:** ***Please provide Certification That You Or The Organization Agree To Be Bound By the Standard Contract Provisions of the District of Columbia.***

I/We, _____ of _____

Hereby give, affirm and provide certification that I/we have received and have read the Standard Contract Provisions For Use With District of Columbia Government and Supply Contracts ("Standard Contract Provisions"), dated October 1, 1999, and agree to be bound by all of the provisions, including the requirements of the Occupational Safety and Health Act of 1970 (as amended), the Service Contract Act of 1965 (41 U.S.C. 351-358), the Buy America Act (41 U.S.C.), and the Non-Discrimination provisions. Further, I/We agree and understand that the Standard Contract Provisions shall be incorporated by reference into any contract or agreement that shall be signed between Me, or My Organization, and the District of Columbia.

| *Name (Please Print)* | *Title* | *Signature* | *Date* |
|---|---|---|---|
| Peggy L. Harris | President | | |

3. **INFORMATION CONSENT:** ***Please Provide Certification That You Or The Organization Provide Consent To The District To Obtain Additional Information As Needed.***

I/We, _____ of _____

Hereby give, provide and express my consent for representatives of the Office of Contracting and Procurement, Government of the District of Columbia, to obtain any information from any professional organization, business entity, individual, government agency, or academic institution concerning the Professional license status or certification referenced in this document. This material shall be held, maintained and updated by the Office of Contracting and Procurement. I further understand that the Office of Contracting and Procurement will use this information solely for internal purposes pertaining to the evaluation of the qualifications of individuals and organizations to provide human care services, as appropriate, in the District of Columbia.

| *Name (Please Print)* | *Title* | *Signature* | *Date* |
|---|---|---|---|
| Peggy L. Harris | President | | |

## SECTION X – TAX CERTIFICATION AFFIDAVIT

1. **TAX CERTIFICATION:** *Please Provide Certification That You Or The Organization Is In Tax Compliance In the District of Columbia.*

Name of Individual/Organization_____

Federal Tax Identification or Social Security No.: _____ ____ DUNS No.: _____

Office of Tax and Revenue Registration No.: _____

Unemployment Insurance Account No.: _____

Names and Addresses of Principal Officers of Corporation: 1.

2. _____
_____

3. _____
_____

**I / We, hereby certify That:**

1. I / We have complied with the applicable tax filing and licensing requirements of the District of Columbia.

2. The following information is true and correct concerning tax compliance for the following taxes for the past five (5) years:

| | | *Current* | *Not Current* | *Not Applicable* |
|---|---|---|---|---|
| District: | Sales and Use | ☐ | ☐ | ☐ |
| | Employer Withholding | ☐ | ☐ | ☐ |
| | Unemployment Insurance | ☐ | ☐ | ☐ |
| | Hotel Occupancy | ☐ | ☐ | ☐ |
| | Corporation Franchise | ☐ | ☐ | ☐ |
| | Unincorporated Franchise | ☐ | ☐ | ☐ |
| | Personal Property | ☐ | ☐ | ☐ |
| | Professional License | ☐ | ☐ | ☐ |
| | Arena/Public Safety Fee | ☐ | ☐ | ☐ |
| | Vendor Fee | ☐ | ☐ | ☐ |
| | Real Property | ☐ | ☐ | ☐ |

3. If not current, as checked in paragraph 2, I am / We are in compliance with a payment agreement with the Office of Tax and Revenue, Office of the Chief Financial Officer. *(Please Attach A Copy Of the Agreement.)* ☐ YES ☐ NO

4. If no outstanding liabilities exist and no agreement has been made, please attach a listing of all such liabilities. The Office of Tax and Revenue also requires:

   (A) Copies of Form FR 532 (Notice of Registration) or a copy of Form FR-500 (Combined Registration).
   (B) Copies of cancelled checks for the last tax period(s) filed for each tax liability, i.e., Sales and Use, Employer Withholding, etc.)

The Government of the District of Columbia is hereby authorized to verify the above information with appropriate government authorities. The penalty for making false statements is a fine of not more than $1,000.00, imprisonment for not more than one (1) year, or both, as prescribed in D.C. Code, section 22-2514. The penalty for false swearing is a fine of not more than $2,500.00, imprisonment for not more than three (3) years, or both, as prescribed in D.C. Code, section 22-2513.

_____ _____
*Signature* *Title*

Subscribed and sworn before me on this _____ day of _____, _____.

Notary Public: _____

My Commission Expires on: _____

*SEAL*

## *SECTION XI – AFFIDAVIT AS TO ACCURATENESS AND TRUTHFULNESS*

I, _____ of being duly sworn on oath, certify that

I am authorized to sign this document and that all of the information contained in this Human Care Agreement Contractor Qualifications Record is complete, true and accurate.

_____ _____

*Signature* *Title*

Subscribed and sworn before me on this _____ day of _____, _____.

Notary Public: _____

My Commission Expires on: _____

*SEAL*